



First Reliance Standard Voluntary Short Term Disability Income Protection

Plan Holder: The Research Foundation of State University of New York
Policy Number: VIP #530237

Choose Your Benefit Amount:

Choose the amount of income you wish to insure up to 60% of your earnings.
Amounts of coverage available: \$100/week up to \$1,250/week (in \$100 increments).

Injury/Sickness:

- ◆ Disability income protection insurance pays a benefit for a disability resulting from a covered injury or sickness. Benefits begin at the end of the elimination period and continue while you are disabled up to the maximum benefit duration.

When Benefits Begin:

- ◆ On the 8th day of your disability.

Maximum Benefit Duration:

- ◆ Injury/Sickness: 26 Weeks.

Plan Highlights

- ◆ Maternity is covered as any other illness.
- ◆ No proof of good health is required if you enroll when you are first eligible to do so.
- ◆ Pre-Existing Condition Limitation applies if you were previously eligible and declined coverage. This limitation applies to a disability within the first 12 months of coverage that is caused by a condition you had within 6 months before coverage begins.
- ◆ Coverage for illness or injury not caused by your job.
- ◆ Definition of Disability: As a result of an Injury or Sickness, during the Elimination Period and during the period for which a benefit is payable, and Insured cannot with reasonable accommodations perform the material duties of his/her Own Job.
- ◆ Benefits payable under this plan will be offset by the New York State Disability Benefits Law (DBL) benefit, as well as other group, individual, and government disability benefits. These offsets are reflected in the rates.

Exclusions

The Policy does not cover any loss caused by: war (declared or undeclared); commission of a felony; intentionally self-inflicted injuries; Sickness which is covered by Worker's Compensation or other workers disability law; Injury which occurs out of or in the course of work for wage or profit.





First Reliance Standard Voluntary Short Term Disability Income Protection Premium Table

Plan Holder: The Research Foundation of State University of New York
Policy Number: VIP #530237

Scheduled Benefit: Each eligible employee may elect an amount of insurance, in increments of \$100 from a minimum of \$100 to a maximum of the lesser of \$1,250 per week or 60% of covered earnings.

You may select any benefit amount from \$100 up to your maximum weekly benefit. Locate your weekly earnings to determine your maximum weekly benefit amount. If your covered earnings fall between ranges, the lesser benefit amount will apply.

Premium Illustrations below are based on bi-weekly deductions.

Weekly Earnings	Weekly Benefit	Age <19	Age 20 - 24	Age 25 - 29	Age 30 - 34	Age 35 - 39	Age 40 - 44	Age 45 - 49	Age 50 - 54	Age 55 - 59	Age 60 - 64	Age 65 - 69	Age 70 +
\$288	\$100	\$1.71	\$1.71	\$1.98	\$1.98	\$1.98	\$1.71	\$1.85	\$2.17	\$2.54	\$2.77	\$3.00	\$3.00
\$334	\$200	\$3.42	\$3.42	\$3.97	\$3.97	\$3.97	\$3.42	\$3.69	\$4.34	\$5.08	\$5.54	\$6.00	\$6.00
\$500	\$300	\$5.12	\$5.12	\$5.95	\$5.95	\$5.95	\$5.12	\$5.54	\$6.51	\$7.62	\$8.31	\$9.00	\$9.00
\$667	\$400	\$6.83	\$6.83	\$7.94	\$7.94	\$7.94	\$6.83	\$7.38	\$8.68	\$10.15	\$11.08	\$12.00	\$12.00
\$834	\$500	\$8.54	\$8.54	\$9.92	\$9.92	\$9.92	\$8.54	\$9.23	\$10.85	\$12.69	\$13.85	\$15.00	\$15.00
\$1,000	\$600	\$10.25	\$10.25	\$11.91	\$11.91	\$11.91	\$10.25	\$11.08	\$13.02	\$15.23	\$16.62	\$18.00	\$18.00
\$1,167	\$700	\$11.95	\$11.95	\$13.89	\$13.89	\$13.89	\$11.95	\$12.92	\$15.18	\$17.77	\$19.38	\$21.00	\$21.00
\$1,334	\$800	\$13.66	\$13.66	\$15.88	\$15.88	\$15.88	\$13.66	\$14.77	\$17.35	\$20.31	\$22.15	\$24.00	\$24.00
\$1,500	\$900	\$16.37	\$15.37	\$17.86	\$17.86	\$17.86	\$15.37	\$16.62	\$19.52	\$22.85	\$24.92	\$27.00	\$27.00
\$1,667	\$1,000	\$17.08	\$17.08	\$19.85	\$19.85	\$19.85	\$17.08	\$18.46	\$21.69	\$25.38	\$27.69	\$30.00	\$30.00
\$1,834	\$1,100	\$18.78	\$18.78	\$21.83	\$21.83	\$21.83	\$18.78	\$20.31	\$23.86	\$27.92	\$30.46	\$33.00	\$33.00
\$2,000	\$1,200	\$20.49	\$20.49	\$23.82	\$23.82	\$23.82	\$20.49	\$22.15	\$26.03	\$30.46	\$33.23	\$36.00	\$36.00
\$2,084	\$1,250	\$21.35	\$21.35	\$24.81	\$24.81	\$24.81	\$21.35	\$23.08	\$27.12	\$31.73	\$34.62	\$37.50	\$37.50

Note: The benefit amount you purchase includes up to \$170 of coverage under the New York State Disability Benefit Law (DBL). Benefits payable under this plan will be offset by the DBL benefit. This premium table reflects the DBL benefit offset.

Rates are subject to change.

This benefit summary outlines some of the features and benefits that we offer in our policy, but it is not a policy.

The actual group insurance policy will contain additional provisions not fully described here.

Any discrepancies between this benefit summary and the group insurance policy, the policy on file at Human Resources will govern.

The provisions are explained in basic terms, and may be subject to change based upon state restrictions.

Coverage is provided under group policy number LRS-9099, et al.



FIRST RELIANCE STANDARD

Life Insurance Company

a DELPHI company

Instructions: Use this form only for cases that offer the employee the ability to purchase voluntary disability coverage. Type or print with ballpoint pen. The employee and the policyholder must each receive a copy of the completed Group Disability Enrollment Form.

Group Disability Enrollment Form

All sections must be completed to ensure accurate processing.	(1) Policyholder/Employer The Research Foundation of State University of New York		(2) FRSL Policy No. VIP 530237		
	(3) Location/Bill Group 1		(4) Full-Time Employment Date / /		
	(5) Class 1		(6) Hours Per Week		
	(7) Job Title		(8) Base Salary \$		
	(9) Employee's Full Name		(10) Payroll Cycle I receive my paycheck:		
Last		First		MI	
(11) Social Security Number - -		(12) Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		(13) Employee's Birth Date / /	
Choose Only One (14) or (15)	(14) Request for Group Insurance Coverage				
	<input type="checkbox"/> I request to purchase STD Coverage in a weekly benefit amount of \$ _____ as described in the Policy. (Please refer to the Premium Table chart.) I authorize my employer to deduct from my salary or wages the necessary premium for the coverage requested above. The signature below also verifies the accuracy of the information contained on this form.				
(15) Declination of Group Insurance Coverage					
<input type="checkbox"/> I have been offered and have declined to purchase the Group Disability Insurance Coverage. I understand that in the event I desire such insurance at a later date: (1) I will be required to furnish evidence of insurability at my own expense; and (2) First Reliance Standard Life Insurance Company (FRSL) will have the right to refuse my request.					

I understand that any coverage will not become effective until and unless approved by FRSL, and upon approval, any benefits payable are subject to the terms, conditions and limitations of the Group Disability Policy. I also understand that the amount of any payroll deduction may be adjusted based on underwriting changes or age changes that affect the rates charged.

_____/_____/_____
 Employee Signature Date

Please sign, date and return this enrollment form to your Campus Benefits Administrator.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.



